Policy Council Document
September 28, 2006
Long-Term Care Reform Plan

Introduction

In May of 2005, the CMS Administrator formed the Policy Council to serve as a vehicle for the Agency's senior leadership to develop strategic policy directions and initiatives to improve our nation's health care system. One of the Council's first priorities was to develop a plan for long-term care reform. To develop the reform plan, the Council created a set of principles for long-term care reform, and then used those principles to develop a vision for long-term care to guide current and future reform activities. This vision was shared with a wide variety of stakeholders and refined based on their input.

The Deficit Reduction Act (DRA) of 2005 was signed into law on February 8, 2006 and included many provisions that target long-term care reform and are consistent with the Agency's vision for long-term care. Implementation of the DRA provisions thus became a key element of the Agency's short- to medium-term strategy for reforming the LTC system. The Policy Council developed an additional set of LTC reform activities to build upon the provisions in the DRA.

This document is intended to serve as a statement of the Agency's long-term care reform plan. It describes the current problems in the long-term care system; the principles for long-term care reform; CMS' vision for long-term care; and additional short- and medium-term steps to achieve long-term care reform. A timeline for implementing the reform activities is attached to this document.

Overview of the Current Problems in the Long-Term Care System

People who need long-term care today need to have more of a real choice about how they get their care. Medicaid, which is the primary source of funding for long-term care, still pays most readily for institution-based care as it has for the last half century. Even when home and community-based options are available, many people are unable to remain in the home because they do not have access to affordable and accessible housing. As a result of these issues, many beneficiaries may be institutionalized when community-based care is a far better match for their needs and preferences.

Payment policies have also created incentives for different care settings to function as "silos" that often do not communicate effectively and thus fail to coordinate care. Antiquated information systems further contribute to a lack of care continuity and coordination. Taken together, these shortcomings compromise patient safety, particularly for the large number of patients with multiple chronic conditions who receive services from multiple providers, and in multiple settings.

Consumers may also fail to get high quality care because they do not have access to the information they need to evaluate the quality of different providers, or to effectively navigate the health care system. As examples of the second point, individuals may not be fully aware of the range of available service options, or may not understand what services the Federal programs cover.

The long-term care delivery system will soon face additional pressures as the baby boom generation ages. The Census Bureau estimates that in 2050 there will be two and a half times more people age 65 or over. At the same time, societal trends such as the dispersing of families and the growing participation rate of women in the workforce will reduce the availability of family caregivers. Paid/professional caregivers are also in danger of being in short supply.

Given that public programs that finance long-term care will soon face unprecedented budgetary pressures, private funding for long-term care services needs to increase. Many Americans do not have an adequate understanding of the costs of long-term care, or of the appropriate role of public programs in financing such care. Public Opinion Strategies and Hart Research, which conducted seven focus groups in four cities in 2004 to explore attitudes and perceptions about long-term care, found that significant barriers to consumer planning for long-term care included denial or lack of awareness about the likelihood of needing long-term care; misconceptions about the actual cost of long-term care; and lack of awareness about available options for planning.

Principles for Long-Term Care Reform

As a first step in addressing the current problems in the long-term care system, the Policy Council developed a set of principles for long-term care reform. These principles are as follows:

- Increase consumer choice and control for older individuals, persons with disabilities and chronic illnesses of any age, their family members and caregivers; and ensure access to an appropriate array of institutional and home and community-based long-term supports;

- Reverse the institutional bias in long-term care services and increase flexibility for States;

- Enhance quality measurement to enable the provision of high-quality long-term care in the setting most appropriate for an individual's needs, and improve quality and oversight in each setting and across settings;

- Reduce costs and promote payment mechanisms that support and reward better performance;

- Encourage personal planning for long-term support needs among individuals and their family members and caregivers, including greater use and awareness of private sources of funding;

- Support Administration efforts to pursue tax law changes for asset accumulation and long-term care tax clarifications to provide for private funding for long-term care needs;

- Improve coordination of long-term care and post-acute care services, as well as their related funding streams; and

- Utilize enhanced health information technology to better inform beneficiary choices, clinical decisions, payment, and care coordination functions.

CMS' Vision for Long-Term Care in the 21st Century

The central concept of CMS' vision for long-term care is that the system will be person-centered; that is, the system will be organized around the needs of the individual rather than around the settings where care is delivered. Consistent with this goal, the vision defines long-term care in terms of the populations who need care. Specifically, long-term care is care that is needed by individuals with long-term disabilities; individuals with frailty and/or dementia associated with aging; individuals with advanced chronic conditions; and other individuals at or near the end of life.

The person-centered system of the future will:
- optimize choice and independence;
- be served by an adequate workforce;
- be transparent, encouraging personal responsibility;
- provide coordinated, high quality care;
- be financially sustainable; and
- utilize health information technology.

Optimizing choice and independence means that beneficiaries will have greater flexibility to choose from a broad spectrum of long-term care services, including home and community-based and facility-based services. The "money will follow the person" to the most appropriate and preferred setting rather than the person following the money to less appropriate and often more costly services. Beneficiaries will also have access to affordable and accessible housing. All of these changes will enable services to be tailored to each individual's unique needs and preferences.

In order to support choice and independence, the system will also have an adequate workforce. Having an adequate workforce means that the labor supply will satisfy the demand for services and that workers will have the proper training to be able to provide high quality care. Compensation and working conditions will enable the system to both attract and retain paid/professional caregivers with appropriate skills. Family caregivers, which are a critical component of the labor force for long-term care services, will have the training and supports they need to be able to provide high quality care to their family members.

In a transparent system, beneficiaries will have access to the information they need to be able to make informed choices and plan for their future care needs. Cost and quality information will enable beneficiaries to compare specific services across different providers. Comprehensive "single entry points" will help beneficiaries to navigate the health care system. Assistance will be available, when needed, to assemble and interpret the information provided through "single entry points."

High quality care will be safe, effective, efficient, and timely. Providing high quality care will sometimes mean using the latest high-tech device, but just as often it will mean providing treatments that prevent complications; social services; coordinated discharge planning; or end-of-life services. Providers will use assessment instruments, in particular, to improve coordination of services, while coordination of Medicare and Medicaid benefits will be enhanced through Special Needs Plans (SNPs) and other mechanisms. Beneficiary quality of life, which depends to a great extent on the strength of relationships between patients and providers, will be improved by optimizing working conditions and job satisfaction for front-line staff.

To ensure sustainability, all Americans will recognize the importance of planning for their long-term care needs, and private financing options will be available and affordable. Some of these private financing options will include long-term care insurance and reverse mortgages. Additional supports will be made available to family caregivers. Finally, Medicaid will continue to protect the most needy.

Information technology will play a key role in supporting several aspects of the vision. In the system of the future, health information technology systems will be implemented in all settings and fully interoperable across settings. Such systems will support the delivery of coordinated, higher quality care. Personal health records will encourage beneficiaries to become more active in managing their care. Information systems will include appropriate privacy protections.

Path to Achieving Reform

Agency Groundwork

The Medicaid program has already been a leader in advancing consumer-directed, person-centered care through various programs and grants. For example, Medicaid programs have included innovations such as self-directed care through "cash and counseling" demonstrations and Independence Plus; expanded the provision of information through Aging and Disability Resource Centers and other "single points of entry"; and provided community-based supports through home and community-based waivers and rebalancing efforts.

CMS has over the past several years identified barriers to community-based long-term care and made a number of policy changes under the President's New Freedom Initiative

that increase access to community-based services. For example, policy changes have permitted the use of nursing facility transition services and expanded the availability of medical equipment to facilitate transition of persons from institutions to the community. CMS has provided guidance to the States through the development of promising practices and papers on re-balancing long-term care and use of "single points of entry", and has provided technical assistance to States on the development of home and community-based waiver programs. In partnership with the Congress, CMS has also made money available to States to implement Real Choice Systems Change grants, Medicaid Infrastructure grants, and Aging and Disability Resource Centers to assist states in building needed infrastructure. These efforts have helped to expand the choices available to persons in need of long-term care services.

The Deficit Reduction Act (DRA) of 2005

Provisions in the Deficit Reduction Act (DRA) of 2005 will further contribute to achieving reform. Several provisions aim to re-balance the system, which will increase beneficiary choice and independence. For example, States will now have the ability the offer home and community based-services and self-directed personal assistance services (cash and counseling) as part of their State plans, without applying for a waiver. The DRA also established an enhanced match rate for implementing Money Follows the Person to assist States in transitioning beneficiaries from institutional to home and community-based care. Five-year demonstrations in up to 10 States will create home and community-based alternatives to psychiatric residential treatment for children.

To support transparency, section 6021(d) of the DRA directed the Secretary to establish the National Clearinghouse for Long-Term Care Information. The Clearinghouse will educate consumers about the availability and limitations of LTC coverage under the Medicaid program; provide contact information for obtaining state-specific information on LTC coverage; provide objective information to assist consumers with the decision of whether or not to purchase LTC insurance; and provide a list of States with State long-term care insurance partnerships under the Medicaid program that maintain reciprocal recognition of long-term care insurance policies issued under such partnerships.

Finally, the DRA contains several provisions that will contribute to ensuring the sustainability of the system. Under section 6021 of the DRA, the Long-Term Care Partnership Program, which was previously available in four States, will become available in all States that take the necessary steps to establish a Partnership Program. Through this program, individuals who have purchased and used long-term care insurance will be able to protect some of their assets from being counted if they apply for Medicaid. They will also be able to protect those assets from being recovered by the State after their deaths. The DRA also provided funds (through the National Clearinghouse) to expand the "Own Your Future" Awareness Campaign. This campaign, which has already been rolled out in nine States, aims to increase consumer awareness about the need to plan for long-term care and provides tools and information to help people plan for their long-term care needs, including by purchasing long-term care

insurance. To ensure that Medicaid is available for the most needy, new asset transfer rules specified under section 6011 of the DRA will increase the look back period on asset transfers to 60 months and the penalty period will begin on the date of the asset transfer or the date that the person would otherwise qualify for Medicaid coverage of LTC expenses, whichever is later. Section 6014(a) of the DRA now specifies that individuals with more than $500,000 in home equity (or up to $750,000 at the State's option) will no longer qualify for long-term care services under Medicaid.

As a next step beyond what is laid out in the plan, CMS must evaluate the changes to the LTC system resulting from the DRA to make mid-course corrections and potentially develop new legislative proposals to further improve the LTC system.

Additional Policy Council Initiatives

Several additional projects are underway to achieve long-term care reform. For example, CMS is communicating the key elements of the Agency's vision for long-term care to a wide variety of stakeholders, including providers, State Medicaid agencies and others, who are essential to creating a person-centered system that offers flexible service options and delivers coordinated, high quality care.

As noted above, one key to ensuring the sustainability of the system is to support family caregivers. To address this critical issue, CMS is working with the Administration on Aging (AoA), which administers the National Family Caregiver Support Program, to identify steps to better support family caregivers.

Long-term care capitation has the potential to reduce costs and improve care quality and coordination, particularly if implemented in the context of Special Needs Plans (SNPs). For example, SNPs that receive capitated payments from Medicare and Medicaid to provide long-term care services will be more likely to use these services judiciously and less likely to shift costs between programs. CMS is synthesizing evaluations of long-term care capitation models to identify the most promising models. The lessons learned will be disseminated through a coordinated outreach effort to States and SNPs.

Finally, care coordination requires that assessment instruments across the entire continuum of care capture the appropriate information and are able to communicate effectively. The Agency is already developing an assessment instrument for use in the Post-Acute Care Payment Reform Demonstration. To build upon that work, the Policy Council will determine the best assessment approach for those in need of long-term care services.

Ongoing Agency Initiatives

Numerous other Agency initiatives are underway that will contribute to long-term care reform in the short- to medium term. Those that relate to improving care quality and coordination include: the Nursing Home Quality Campaign; the Nursing Home Staff

Time Measurement Study; the Nursing Home Quality-Based Purchasing Demonstration; the Home Health Pay for Performance initiative; and Durable Medical Equipment (DME) Competitive bidding. A resource that relates to supporting an adequate workforce is the National Direct Service Workforce Center and an initiative that relates to utilizing information technology is the Minnesota E-Prescribing Pilot Program. All of these initiatives are included on the attached timeline for implementing long-term care reform.

Agency Partnerships

CMS' vision for long-term care broadens the scope of what is traditionally viewed as the long-term care system to include elements such as housing and labor. Partnerships with other parts of the Federal government will be necessary to achieve reform in these areas. For example, CMS is working with the Department of Housing and Urban Development (HUD) to explore options for the provision of long-term care services for beneficiaries living in affordable housing, and with the Assistant Secretary for Planning and Evaluation (ASPE) and the Administration on Aging (AoA) to strategize on how to develop reverse mortgage programs. The Agency is collaborating with AoA, the Administration for Developmental Disabilities (ADD) and non-HHS Agencies such as the Department of Labor (DOL) and the Department of Education (DOE) to address workforce issues. Moving forward, CMS will continue to look for opportunities to partner with others in order to achieve reform and realize its vision for long-term care in the 21st century.

Conclusion

Reforming the current system will lead to a long-term care system which optimizes choice and independence; encourages personal responsibility; provides seamless, coordinated and flexible supports; and promotes physical and mental health and functioning. We expect the reformed system to be more efficient and sustainable. Making this vision a reality will be challenging work, requiring the best of research, community commitment, family loyalty, and creative leadership. As the population ages, we have a few years now to make major changes before the expected increase in persons needing long-term-care. A reliable and efficient set of arrangements for long-term care is good policy that will allow Medicare and Medicaid to better serve the people who most need the help that these public programs can provide.